

A copy of this authorization shall be valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the Board, located at 444 N. Third Street, Suite 410, Sacramento, CA 95814. My written revocation will be effective to the extent that such persons have acted in reliance upon this authorization. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization if requested by me.

Signature: _____
Patient Date

Or:

Legal Representative Relationship Date

NOTE TO THE PROVIDER: This release is compliance with the requirements of HIPAA and Civil Code Section 56.11.